Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING_ NVS2835HIC 01/06/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5565 O'BANNON** AND YOUR HOME TOO 3 LAS VEGAS, NV 89102 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) H 000 Initial Comments H 000 acceptable for 723/0-Deegenla, HFSII Initial Comment This Statement of Deficiencies was generated as a result of a State Licensure survey and Complaint Investigation conducted in your facility on 1-6-09. This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care, adopted by the State Board of Health on November 29, 1999. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal. state or local laws. The census at the time of the survey was two. There was one complaint investigated during the Complaint #NV00020391 Unsubstantiated The following regulatory deficiencies were identified. HDII H 011 H 011 Director Duties-Needs Assessment NAC 449.15523 Director: Duties. (NRS 449.249) The director of a home shall: 2. Ensure that the needs of each resident of the home are assessed upon admission of the resident to the home, and that the assessment is updated as the needs of the resident change.

If deficiencies are cited/an approved plan of correction must be refurned within 10 days after receipt of

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Bureau e	of Health Care Quali	ty & Compliance				FORM A	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED			
		NVS2835HIC				01/06	6/2009
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
AND YOU	UR HOME TOO 3		5565 O'B	ANNON AS, NV 891	02		
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H 011	Continued From pa	ge 1		H 011	siled after ever	y unde	to
: :	This Regulation is Based on interview failed to ensure the assessment (ADL) admission for 1 of 2 Findings include:	not met as evidence and record review, t activity of daily living was completed upor 2 residents (Resident	he facility I I I #2)	Sept	Director will so for accuracy. C) January 9+1		we.
Н 042	no documented evidence of an ADL assessment. Employee #1 indicated she requested the information from another facility. The employee did not have an answer as to why the assessment was not completed.		H 012	H012	, <i>0</i> ;		
	The director of a hour 2. Ensure that the rehamme are assessed resident to the home updated as the neel Such an assessme	rector: Duties. (NRS ome shall: needs of each reside d upon admission of e, and that the asset ds of the resident ch must include: of the abilities of the	nt of the the ssment is ange.		A). Resident #2 Was misfiled computer pers File was foun after Surveyors B). Files will be p	on. d 3day Visit.	1/23/09
	Based on interview failed to ensure the assessment (ADL)	not met as evidence and record review, t activity of daily living was completed upor residents (Resident	he facility I		The Director is montitor for ac	rill curacy	
i	-						

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Resident #2 was admitted on 8/16/08. There was no documented evidence of an ADL assessment.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		NVS2835HIC		B. WING _		01/0	6/2009		
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE				
AND YOU	UR HOME TOO 3		5565 O'BANNON LAS VEGAS, NV 89102						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE		
H 012	Continued From pa	ige 2	Ì	H 012					
					H013	. 70			
H 013	Director Duties-List	Needed Assistance		H 013	A) Resident#20	, fill wa	<u>م</u> آ		
	The director of a hour 2. Ensure that the rehome are assessed resident to the home updated as the neel Such an assessme	needs of each reside d upon admission of e, and that the asse- ds of the resident ch nt must include: of the matters for wh	nt of the the ssment is ange.		mis-filed by con serson. File w 3 days after wout. B) Files will be filed after ever	Adpliler as four Surveyo e proper ry updo	1, 1/2%		
	Based on interview failed to ensure the assessment (ADL)	not met as evidence and record review, t activity of daily living was completed upor 2 residents (Residen	he facility		monitor for a	scuraci			
	Findings include:								
:		dmitted on 8/16/08. dence of an ADL ass					,		
		ated she requested the nother facility. The en							

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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assessment was not completed.

sanitation of facility. (NRS 449.249)

NAC 449.15525 Requirements for safety and

H 033 Safety&Sanitation-First Aid Kit

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H 033

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		NVS2835HIC		B. WING _		01/06	6/2009		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY,	STATE, ZIP CODE				
AND YOU	JR HOME TOO 3			5565 O'BANNON .AS VEGAS, NV 89102					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE		
H 033	Continued From pa 2. A home must co (c) A first-aid kit;	_		Н 033	first-aid Kits will be main @ all times.	tained Directi	1/27/0		
	Based on observati failed to ensure ma kit. Findings include:	not met as evidence on and interview, the intaining a complete	e facility first aid		will monitor and Kits month	furst-	,		
H 043	Resuscitation (CPR	imployee #2 revealed in the facility.	d there	H 043	HO43 A) Resident #25	; file	7/23/09		
	home and resident maintenance of rec 449.249) The operator of a h 2. Maintain a separ resident of the hom years after the resid home. Each file mu (b) The address an	ords of residents. (Nome shall: ate, organized file fore and retain the file for th	RS r each for 5 ves the of the		A) Resident #25 was mis-filed computer perso was located 3d after surveyors B) Files will be filed after every	aip visit	DS ly		

residents (Resident #2).

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure the resident's physician was documented in the resident file for 1 of 2

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Bureau d	of Health Care Quali	tv & Compliance					02/02/2009 APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED		
		NVS2835HIC	070f57.40	DD500 OFW	OTATE TIP CORE	<u> 01/00</u>	6/2009
NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
AND YOU	UR HOME TOO 3		5565 O'B	ANNON AS, NV 891	02		
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H 043	Continued From pa	ge 4		H 043			
	no documented evi physician, the phys number in the resid Employee #1 indica person to update th	dmitted on 8/16/08. dence of the name of ician's address and pent's file. ated she hired a come charts. The emploface sheet for the re	of the obbone puter byee was			Λ	
H 044	NAC 449.15527 Ag home and resident maintenance of rec 449.249) The operator of a h 2. Maintain a separ resident of the hom years after the resid home. Each file mu (c) A copy of the res	ords of residents. (Nome shall: ate, organized file fo e and retain the file t dent permanently lea	RS r each for 5 ves the ysical	H 044	A) Resident #2's to missisled by le persond. File was le 3 days after sur visit. B). Files will be f when after every The chrector we monitor for acc c). 1-9-09	veyor's roperty updat	1 1 1 1 0 9 1 - 3 5 1 e.

This Regulation is not met as evidenced by: Based on interview and record review, the facility

failed to ensure a physical examination was

performed for 1 of 2 residents (Resident #2).

Findings include:

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Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

(X3) DATE SURVEY COMPLETED

NVS2835HIC

B. WING

01/06/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

I AND VOUR HOME TOO 2		5565 O'B/ LAS VEG/	ANNON AS, NV 8910	02	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 044	Continued From page 5		H 044		
	Resident #2 was admitted on 8/16/08. To documented evidence of a physical examination in the resident's file.	There was	·		
	Employee #1 indicated she had requested the information from the facility the resident had been at prior to admission. The employee was unable to provide a reason why the information is not in the resident's file.			H045	
H 045	Records of Residents-Current Needs Assessment		H 045	[• • • • · · · · · · · · · · · · · · ·	1/13/09
	NAC 449.15527 Agreement between ophome and resident concerning rates; maintenance of records of residents. (N 449.249) The operator of a home shall: 2. Maintain a separate, organized file for resident of the home and retain the file file years after the resident permanently leahome. Each file must include: (d) A current copy of the assessment of needs of the resident conducted pursua 449.15523.	RS r each for 5 ves the the	er e	A) Resident #2's file was mispled by computer person. File was located 3 days after survenyor's visit. B). Files will be preperly illed after every update. Derector will monitor for accuracy. c). 1-9-09	7/10/07
	This Regulation is not met as evidenced Based on interview and record review, to failed to ensure the activity of daily living assessment (ADL) was completed upon admission for 1 of 2 residents (Resident	he facility I I			
	Findings include:				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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PRINTED: 02/02/2009 Bureau of Health Care Quality & Compliance (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING _ NVS2835HIC 01/06/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5565 O'BANNON** AND YOUR HOME TOO 3 **LAS VEGAS, NV 89102** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) H 045 H 045 Continued From page 6 Resident #2 was admitted on 8/16/08. There was no documented evidence of an ADL assessment. Employee #1 indicated she requested the information from another facility. The employee did not have an answer as to why the assessment was not completed. H060 H 060 H 060 Ultimate User Agreement NRS 453.375 Authority to possess and administer controlled substances. A controlled substance may be possessed and administered by the following persons: 6. An ultimate user or any person whom the ultimate user designates pursuant to a written agreement. NRS 454.213 Authority to possess and administer dangerous drug. [Effective through December 31, 2007.] A drug or medicine referred to in NRS 454.181 to 454.371, inclusive. may be possessed and administered by: An ultimate user or any person designated by the ultimate user pursuant to a written agreement.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to ensure an ultimate user agreement was signed for 1 of 2 residents (Resident #2).

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Findings include:

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Bureau of Health Care Quality & Compliance

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	[V = / · · · · · · · · · · · · · · · · · ·	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER

AND YOUR HOME TOO 3 LAS VEGA		GAS, NV 89102			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE. (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 060	Continued From page 7		H 060		
	Resident #2 was admitted on 8/16/08. Twais no documented evidence of an ultilagreement.				
	Employee #1 did not have an answer as the assessment was not completed.	to why			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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